A Practical Guide
for
Child Care Health Consultants

(Appendices are not included in this web version)

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Healthy Child Care Hawaii

Promoting Health and Safety in Child Care

A Collaborative Project:

Hawaii Department of Health - Children with Special Health Needs Branch
University of Hawaii - School of Medicine - Department of Pediatrics
American Academy of Pediatrics – Hawaii Chapter
Hawaii Department of Human Services

A Practical Guide For
Child Care Health Consultation

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CHAPTER I
Introduction

Healthy Child Care Hawai`i (HCCH) is pleased to present this *Practical Guide for Child Care Health Consultation*. We hope the information is useful for health consultants at child care centers in the community.

HCCH promotes health and safety in child care. HCCH goals are to:

- Develop a statewide network of child care health consultants.
- Provide opportunities for pediatricians-in-training to teach developmental and health topics to parents and child care staff.
- Promote the use of "Caring for Our Children" the National health and safety guidelines.
- Promote access to health services for children in child care.

HCCH is a collaborative effort of the Hawai`i Department of Health/Family Health Services Division, University of Hawai`i, School of Medicine, Department of Pediatrics, the American Academy of Pediatrics, Hawai`i Chapter and the Hawaii State Department of Human Services. HCCH was funded by the federal Maternal and Child Health Bureau, presently funded by the Hawaii State Department of Human Services. The Healthy Child Care America Campaign is based on the principle that families, child care providers, and health care providers in partnership, can promote the healthy development of young children in child care and increase access to preventive health services and safe physical environments for children.

Mahalo to all child care health consultants for their contribution to the health and safety of young children in child care.

CHAPTER II

Standards For Health And Safety In Child Care

A. MEDICAL HOME

All children should have a medical home. As defined by the American Academy of Pediatrics, "A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician or physician whom they trust. The pediatric health care professionals and parents act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential." (See Appendix 1.)

In a medical home, care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally-effective.

B. "CARING FOR OUR CHILDREN" NATIONAL STANDARDS

Child care standards represent the goals of child care practice, i.e., the level of practice child care programs voluntarily seek to attain. In 1990, the National Research Council Report of the National Academy of Sciences recommended the adoption of uniform national child care standards-based on current knowledge from child development research and best practice from the fields. This was followed by the 1992 publication by the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) of the "Caring for Our Children - National Health and Safety Performance Standards – Guidelines for Out-of-Home Child Care" (CFOC). In 2002, the second edition of the CFOC was published as a joint collaboration project of the National Resource Center for Health and Safety in Child Care (NRC), the APHA and the AAP. These national standards are the highest health and safety standards for out-of-home child care available in the United States. The standards are available at: http://nrc.uchsc.edu/CFOC/index.html

Standards include the following areas: staffing, program activities for healthy development, program: health protection and health promotion, nutrition and food service, facility, supplies, equipment, transportation, infectious diseases, children with special needs.

C. MODEL CHILD CARE HEALTH POLICIES

(Pennsylvania Chapter of the American Academy of Pediatrics)

The Pennsylvania Chapter of the American Academy of Pediatrics developed "Model Child Care Health Policies" for out-of-home child care. These policies use guidelines from "Caring for Our Children." The model policies are available at: http://www.ecels-healthychildcarepa.org

These policies can be used by any type of child care facility, and can be adapted to the individual child care setting and/or to meet state or other requirements.

D. HEALTHY YOUNG CHILDREN: A MANUAL FOR PROGRAMS

(National Association for the Education of Young Children)

The National Association for the Education of Young Children (NAEYC) is a national organization of early childhood educators and others who are dedicated to improving the quality of programs from birth through third grade.

"Healthy Young Children: A Manual for Programs" is a basic manual used by early childhood programs to promote the health and safety of children, staff, and families.

E. LICENSING RULES FOR CHILD CARE

(Hawaii Department of Human Services)

All 50 states impose varying degrees of regulation on at least some types of child care through licensing procedures. These regulations impose minimum health and safety requirements for compliance.

In Hawaii, regulations for child care are established by the Department of Human Services (DHS). The regulations address requirements and standards for administration, program, staffing, health of children, health of staff, environment, physical facility, nutrition, and program modifications.

The DHS regulations (see Appendix 2) are:

- *Licensing of Infant and Toddler Child Care Centers (Title 17, Chapter 895)*

  These centers provide care for children age 6 weeks and older.

- *Licensing of Group Child Care Centers and Group Child Care Homes (Title 17, Chapter 892.1)*

  These centers/homes serve children age 2 years (24 months) and older. The term "child care center" includes day nurseries, nursery school groups, preschool child play groups, group child care home, etc.

- *Registration of Family Child Care Homes (Title 17, Chapter 891.1)*

  These homes have 3 to not more than 6 children, who are unrelated to the child care provider by blood, marriage, or adoption.

CHAPTER III

Child Care Health Consultation

A. ROLE OF CHILD CARE HEALTH CONSULTANT

A child care health consultant is defined as "a health professional who has an interest in and experience with children, has knowledge of resources and regulations and is comfortable linking health resources with facilities that provide primarily education and social services" (Caring for Our Children, 2nd ed.). The health consultant's role is to:

- Encourage child care programs to implement the Caring for Our Children (CFOC) standards in order to promote and establish best practice of child care health and safety in their facilities, and

- Enhance the ability of the child care program to provide high quality care by acting as a resource to arrange for the provision of health services and health education.

B. DEVELOPING A COLLABORATIVE RELATIONSHIP

Health consultation is most effective when it is provided in the context of a trusting and consistent relationship between the consultant and child care center. To develop collaboration:

- Promote a relationship in which the health consultant and child care center staff work together to improve health and safety in child care.

- Recognize and respect the knowledge, skills, and experience that both the health consultant and child care center staff bring to the relationship.

- Create an atmosphere in which the cultural traditions, values, and diversity of the health consultant and child care center staff are acknowledged and honored.

- Recognize the mutual commitment of the health consultant and child care center staff to meet the needs of children and their families.

- Have a shared vision of how things could be different and better.

- Facilitate open communication so that the health consultant and child care center staff feel free to express themselves.

- Recognize that negotiation is essential in a collaborative relationship.

- Establish some practical guidelines for contacts. For example:
  - Who is the contact person at the child care center ? (e.g., director, staff person, other)
  - How do you want to be contacted? (e.g., telephone, fax, e-mail)
  - When do you want to be contacted? (e.g., anytime, during specific hours, regularly scheduled basis, etc.)

(From: "Family-Centered Interprofessional Collaboration" in *Suggested Guidelines for Physician Consultants & Early Childhood Directors*, 1998; and *Pediatrician's Role in Promoting Health and Safety in Child Care*)

C. GETTING TO KNOW THE CHILD CARE CENTER

- Learn about the child care center:
  - How long has the program been in operation?
  - How many children attend the program? How old are the children?
  - How are children grouped?
  - What special health care needs do the children have?
  - How many staff members are with the program?
  - What are the hours of operation?
  - Is the child care center accredited through an organization?
  - Are there any special characteristics of the child care center, children, or families served (teen parents, ethnic background, etc.)?
  - What are the child care center's needs for health policies, staff, parent, or child training on health issues?

- Visit the child care center. Some things to observe:
  - Activities: drop-off or pick-up of children by parents, quiet and active play, food service, naptime, diapering and toileting, etc.
  - Staff-child interactions.
  - Practices: supervision, infection control, safety, nutrition, etc. Are they developmentally appropriate?
  - Facility: entrances, exits, hallways, indoor and outdoor play areas, food preparation and storage areas, restrooms, etc.
  - Meet with the child care center director.
  - Identify child care center's strengths.
  - Identify child care center's wants and needs.
  - Identify most important health concerns.
  - Discuss roles for the health consultant.

(From: *Pediatrician's Role in Promoting Health and Safety in Child Care*)

D. PROVIDING HEALTH CONSULTATION

Child care health consultation focuses on health issues that apply to the children, families, and staff as a group, rather than on individual children. Examples of group issues include infection control measures to prevent the spread of disease, nutritious snacks and meals, and playground safety to prevent injuries.

A health consultant's involvement may range from minimally (e.g., provides information over the telephone) to extensive (e.g., provides advice and educational activities at the child care center). Together the health consultant and child care center can identify what the child care center wants and whether it matches the health consultant's expertise, availability, and desired role.

The following are services that a health consultant might provide.

1. Promote health and safety

a. Provide health and safety education and information.

- Provide education and information on various aspects of care, activity, or facility that relate to the child care center's prevention and management of illness and injury and to the enhancement of the child's development.
- Provide information on health issues such as new health recommendations, regulations that affect child care practices, emerging health issues, immunization schedules, or other concerns.
- Conduct health education presentations for staff, parents, and/or children on topics to promote health and safety, such as on child development, physical and mental health, nutrition, injury prevention, preventive health care, oral health care, etc.

b. Provide ongoing health consultation upon request

- Respond to health questions, needs, or issues as they arise. Recommendations should reinforce and build on positive things already being done, be cost-effective, and be easily implemented. Advice should be clear and simple, outlined verbally and in writing, if possible.
- Information and advice may be provided by telephone, fax, e-mail, or in-person at the child care center. Referrals to other resources may be given.

c. Develop and review child care health policies

- Child care centers should have written health policies that cover a broad range of child and staff health concerns. Policies may be developed or reviewed to ensure consistency with Caring for Our Children standards. Examples of policies include administration of medicine, first aid kit, etc.
- Model policies may be used to help child care centers in developing or revising health policies. See "Model Child Care Health Policies" (Pennsylvania Chapter of the American Academy of Pediatrics).

- **Review illness and injury logs**
- As needed, advise the child care center to keep records of illnesses and injuries experienced by children and staff at the center. The form should include date, time, child involved, where injury occurred, during what activity, equipment involved, type of injury, severity of injury, action taken, etc.
- Help the center to review the illness and injury logs periodically, to identify patterns. Work with the staff to develop plans to improve the prevention and management of illness and injury at the center.

2. Promote access of children/families to health and other services

- Ensure that all children have medical homes and preventive care. Encourage child care providers to talk with families about the importance of a medical home, or offer referrals to primary health care professionals in the community, as appropriate. Encourage child care providers to provide information about Medicaid/QUEST, as appropriate.
- Provide information about community health resources that are available for children and their families.

3. Promote the inclusion of children with special needs in child care

- Advocate for the inclusion of children with special needs.
- Help child care staff prepare for children with special needs in the center. Preparations may include:
  - Establishing communication with the family and health care providers.
  - A plan or protocols for the child's routine and emergency care.
  - Accommodations may be needed for activities, nutrition, medications, health procedures, equipment, and facilities.
  - Getting medications and supplies.
  - Training staff in special procedures.

E. CFOC STANDARDS FOR HEALTH CONSULTANTS

- Each Center, large family child care home, and small family child care home shall have a health consultant who is a health professional with training and experience as a child care health consultant. (S 1.040-1.041)
- Frequency of child care health consultation visits (S 1.043)
- The facility shall specify in its policies what severity level(s) of illness the facility can manage and how much and what type of illness will be addressed. The plan of care shall be approved by the facility's health consultant. (S 3.064)
- The facility shall have written policies to specify how the caregiver addresses the developmental functioning and individual needs of children (including children with special needs) served by the facility. These policies shall include but not limited to: use of health consultants (S 8.004, 8.005), discipline policy (S 8.010), and plan for the care of acutely ill children and caregivers (S 8.011).
- At least annually or when changes are made in the health policies, the facility shall obtain a review of the policies from a health consultant. (S 8.041)

- Documentation of health consultation/training visits shall be maintained in the facility's file. (S 8.073)
- State agencies should encourage the arrangement of and the fiscal support for consultants from the local community to provide technical assistance for program development and maintenance. (S 9.033)

F. LEGAL LIABILITY FOR HEALTH CONSULTANTS

To promote the highest standard of care and to limit the liability for consulting activities, the most current recommendations from national authorities, such as American Academy of Pediatrics, etc., should be used.

Health consultation activities should be recorded, including: date, person to whom consultation was provided, reason for consultation, and information or advice provided.

Health consultants should share a description of child care responsibilities with their medical malpractice insurance carrier and ask for written confirmation of coverage for these activities, noting any restrictions or the need for additional coverage.

(From: *Pediatrician's Role in Promoting Health and Safety in Child Care*)

REFERENCES

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002 http://nrc.uchsc.edu

- National Training Institute for Child Care Health Consultants Staff. Building Consultation Skill Part A & B. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001

- American Academy of Pediatrics. The Pediatrician's Role in Promoting Health and Safety in Child Care. American Academy of Pediatrics, Johnson & Johnson Pediatric Institute, 1999 www.aap.org

CHAPTER IV - Promoting Health and Safety

A. Oral Health

Background

- Among U.S. children, dental decay is one of the most common chronic infectious diseases. 17% of children have already experienced tooth decay by the time they are 2-4 years old. Among low-income children, almost 50% of tooth decay remains untreated.
- In Hawaii, young children have twice the rate of tooth decay compared with mainland children. Hawaii children age 5 years have an average of 3.9 decayed teeth compared to mainland U.S. children age 5 years who have an average of 1.9 decayed teeth.
- The pain and infection caused by tooth decay can lead to problems in eating, speaking, and the ability to learn.
- Early tooth loss caused by dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem. Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life.

(Center for Disease Control and Prevention; Dental Health Division, Hawaii Department of Health; "Trends in Children's Oral Health" and "Oral Health and Learning", National Center for Education in Maternal and Child Health)

Role of the health consultant in promoting oral health

- Educate the child care providers in how to incorporate good oral health practices into the children's daily routine. For example - cleaning teeth and gums, storage of toothbrushes, and nutrition.
- Educate parents and child care providers about easy oral disease prevention methods, understanding major oral health problems, and how to respond to oral health emergencies.
- Provide resource information to child care providers so they can assist children and families in receiving needed oral health services. For example, how to choose a dentist, insurance information, etc.
- Assist child care providers in preparing for dental emergencies.

CFOC standards for oral health

- All children with teeth shall brush or have their teeth brushed at least once while they are in child care. The caregiver shall be knowledgeable about the correct brushing method and shall monitor the tooth brushing activity. After feeding, an infant's teeth and gums shall be wiped with a moist cloth. When brushing is not possible, children shall be offered drinking water after snacks. (S 3.010)
- In facilities where tooth brushing is an activity, each child shall have a personally labeled toothbrush. Toothbrushes shall be replaced every 6 months or sooner if bristles have lost their tone. (S 5.095)
- Toothbrushes shall not be shared and shall be labeled with the name of the child. (S 5.094)

- Toothbrushes shall be stored so that they do not drip on other toothbrushes, and shall be

separated from one another, bristles up exposed to the air to dry, and not in contact with any surface. (S 5.095)

- All children 2 years of age or older shall receive oral health education and practice as a part of the daily facility activities. Oral health education shall include information on prevention of oral disease and promotion of oral health (tooth brushing, flossing, water fluoridation, use of dietary fluoride supplements and dental sealants, regular dental visits, avoidance of tobacco, and a healthy diet). Oral health shall be included as a part of health education. (S 3.011)
- Caregivers should promote proper oral hygiene and feeding practices including proper use of the bottle for all infants and toddlers. (S 4.014)

Reference

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002

- National Training Institute for Child Care Health Consultants Staff. Caring for children who are abused or neglected. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001

Where to find more information

▪ American Academy of Pediatric Dentistry	*www.aapd.org*
• American Dental Association	*www.ada.org*
• Academy of General Dentistry	*www.agd.org*
• National Maternal and Child Oral Health Resource Center	*www.mchoralhealth*.org
• National Resource Center for Health and Safety in Child Care	*nrc.uchsc.edu*
• Bright Futures	*www.brightfutures.org*
• Oral Health Resources, National Center for Chronic Disease Prevention and Health Promotion, Center for Disease Control and Prevention	*www.cdc.gov/oralhealth/ index.htm*
• Hawaii Covering Kids Project (Medicaid/QUEST) Kids Health Insurance Information Hotline Ph. 275-2000 (Oahu) 1-877-275-6569 (Neighbor Islands)	*www.coveringkids.com*
• Department of Health / Dental Health Division Ph. (808)832-5700 Fax (808)832-5722	*www.hawaii.gov/health/ family-child-health/dental/*

CHAPTER IV - Promoting Health and Safety

B. Injury Prevention

1. PLAYGROUND INJURY

Background

- Each year, about 200,000 children ages 14 and younger are treated in US hospital emergency rooms for playground equipment-related injuries.
- The National Program for Playground Safety (2004) estimates that more than 40% of playground injuries may be due to inappropriate or a lack of adult supervision.
- In child care facilities, most injuries occur in the playground.
- The age group that sustains the most injuries is the 2-3 year olds.
- Falls are the most common type of injury.
- The head (face, eyes, nose, and mouth) is the most frequently injured part of the preschool child's body.
- The Value of Outdoor Play
  - Children learn through play.
  - A high quality outdoor environment can provide children with the opportunity to creatively explore new ideas, skills, and behaviors during play.
  - Play is a relatively risk-free opportunity for children to challenge themselves and develop a sense of confidence and self-esteem.
  - Outdoor play and exposure to the natural world provides an avenue for children to learn and develop important physical, emotional, social, and cognitive skills that cannot be offered indoors (McGinnis, 2000).

Role of child care health consultant in reducing the risk of playground injury

- Assist child care provider to develop and periodically review daily and monthly playground maintenance and supervision plan.
- Recommend all playground structures be repaired to comply with CPSC standards. (Handbook for Public Playground Safety: www.cpsc.gov or write: US Consumer Safety Commission, Washington, DC 20207; or call (800) 638-2772)
- Recommend all structures that cannot be changed to comply with CPSC standards be removed.
- Act as a liaison with community pediatricians to distribute safety information to parents and providers.

CFOC standards for playground maintenance [*CFOC* standards 5.162-5.197 on playground safety]

- Policy on use and maintenance of play areas. (S 8.033)
- Play equipment requirements. (S 5.085, 5.086)
- Size and location, capacity, enclosure of outdoor play area. (S 5.162, 5.164-5.169, 5.176-5.179)
- Design, and safety installation of play equipment. (S 5.168-5.175, 5.180-5.189)
- Proper ground surfacing (S 5.183)

- Removal of hazards: (S 5.190-5.194)
  - Broken glasses, trash and other foreign materials
  - Areas of poor drainage and accumulation of water, walking service hazards
- Regular inspection of play area and equipment by the child care providers to both examine deterioration of structures and initial correction or removal of hazards. (S 5.195-5.197)
  - Resilient material beneath playground equipment
  - Visible cracks, bending or warping, rusting, or breakage of any equipment
  - Deformation of open hooks, shackles, rings, links and so forth
  - Worn swing hangers and chains
  - Missing, damaged or loose swing seats
  - Broken supports or anchors
  - Cement support footings that are exposed, cracked or loose in the ground
  - Accessible sharp edges or points
  - Exposed ends of tubing that require covering with plugs or caps
  - Protruding bolt ends that have lost caps or covers
  - Loose bolts, nuts and so forth that require tightening
  - Splintered cracked or otherwise deteriorating wood
  - Lack of lubrication on moving parts
  - Worn bearings or other mechanical parts
  - Worn or scattered surfacing material
  - Chipped and peeling paint
  - Pinch or crush points, exposed mechanisms
- The child care facility shall maintain all information and records pertaining to the manufacture, installation and regular inspection of facility playground equipment. (S 8.071, 8.072)

Where to find more information

- American Society for Testing and Materials *www.astm.org*
- National Recreation and park Association. (1998) Playground Surfacing Materials (US CPSC Document #1005) www.nrpa.org/playsafe/surfaces
- Centers for Disease control and Prevention www.cdc.gov
- Educational Development Center, Inc www.edc.org
- U.S. Consumer Product Safety Commission www.cpcs.gov

2. CHOKING, STRANGULATION, SUFFOCATION AND ENTRAPMENT

Background

- Four principal causes of asphyxiation in children are: choking, entrapment, strangulation and suffocation (they all imply compromised airflow).
- The following foods are potentially harmful for children under age four in the child care setting (Widome, 1997 and AAP2001):

Hot dog and sausages	Peanuts or nuts
Grapes	Raisins

Chunks of meat or cheese	Apple chunks
Watermelon seeds	Raw carrots and other vegetables
Hard or sticky candy	Popcorn
Chewing gum	Chunks of peanut butter

- The following toys and objects in particular are potentially harmful for preschool age children (California Child Care Health Project, 1991 and AAP 2001):

Marbles	Erasers
Jacks	Pins
Necklace-like toys	Nails
Balloons	Crayons
Play jewelry	Toothpicks
Game tokens	Plastic bags
Coins	Pen and marker caps

Any toy less than 1-3/4 inches in diameter
Small button-type batteries (i.e., a watch battery)
Toys that can be compressed to fit entirely into a child's mouth
Medicine syringes
Small balls [Any ball with a diameter of 1.75 inches (44.4 mm) or less is a choking hazard for children under the age of 3 (CPSC, 1995)]

Role of the health consultant in reducing the risk of airway obstruction hazards

- Ensure that the child care provider receives training in the prevention of choking, suffocation, strangulation, and entrapment and how to reduce the risks.
- Assist the provider in educating parents about airway obstruction hazards.
- Assess and identify potential airway obstruction hazards in the child care facility.
- Provide educational materials for providers and parents about emergency procedures to follow in case of compromised airflow.

CFOC standards regarding asphyxiation

- To prevent entrapment, CFOC recommend precaution in the following:
  - Finger-pinch protection devices shall be installed wherever doors are accessible to children. (S 5.017)
  - Equipment, materials, furnishing shall meet the recommendations of the CPSC. (S 5.075)
  - Infants shall be placed on their back on a firm mattress. Soft beddings and toys shall be removed. (S 5.146, 5.145)
  - Closet doors shall have an internal release for any latches. (S 5.156)
  - Stairway guards such as gates shall have latching devices that adults can open easily. (S 5.225)
  - All pieces of play equipment shall be designed to guard against entrapment or situations that may cause strangulation. (S 5.186)
- Choking
  - A staff shall check all play equipment at least monthly. (S 3.038)
  - Commercially packaged baby food shall be served from a dish, not directly from the container or in a bottle. (S 4.021) ,
  - Child care providers shall not offer to children under 4 years old foods that are

implicated in choking incidents. (S 4.037)
  - Small objects and toys available to children under the age of 3 years shall meet the federal small parts standards for toys. (S 5.087)
- Strangulation
  - Crib gyms present potential strangulation hazards for infants. (S 5.088)
  - Cribs shall meet U.S. CPSC standards. (S 5.145)
  - Plastic bags shall be stored out of reach of children. (S 5.159)
  - Helmets shall be removed before allowing children to use playground equipment. (S 5.092)

3. POISONING

Background

- "In 2002, more than 111,000 children ages 14 and under were treated in hospital emergency rooms for unintentional poisoning. Nearly 80 percent of these injuries were to children ages 4 and under" (Safe Kids Worldwide, 2004)
- The substances most common poison exposures for children are cosmetics and personal care products, cleaning products, pain relievers, foreign bodies, and plants (Litovitz 2001)
- Types of Poisonings

  Household Products
  - The most dangerous poisons include:

Medicines, including iron pills	Antifreeze
Windshield washer fluid	Drain opener
Toilet bowl cleaner	Oven cleaner
Rust remover	Furniture polish
Lighter fluid	Carbon monoxide
Pesticides	Wild mushrooms
Paint thinner	Turpentine

    (American Association of Poison Control Centers, 2004)

  - *Common* household poisons include:

Mouthwash	Hair removal products
Nail polish	Cold medicines
Pain relievers	Hairspray
Cologne/Perfume	Make-up
Alcohol (all types)	Toothpaste

    (American Association of Poison Control Centers, 2004)
- Childhood lead poisoning is considered one of the most preventable environmental diseases of young children, yet ~1 million children have elevated lead levels (CDC 2001)
- Five ways poisoning occurs:
  - Bites and stings
  - Ingestion
  - Inhalation

  - Skin contact
  - Puncture/Injection
- Contact the Hawaii Poison Center immediately for advice when poisoning is suspected and there is no observable untoward effects. Toll free number is (800) 222-1222.
- Activate established plan for emergency measures and response when poisoning occurs.

Role of the health consultant in reducing the risk of poisoning

- Educate providers and parents about ways poisoning may occur and provide educational materials and instructions on appropriate actions and resources.
- Provide consultation and assist in development of emergency procedures to prepare and guide staff.
- Recognizing the Signs of Poisoning
  - The following conditions suggest the possibility of poisoning:
    - Nausea, vomiting or sudden cramps
    - Coughing or shortness of breath
    - Cold, clammy skin
    - Burns around the mouth
    - Disoriented, slurred speech
    - Dizziness, drowsiness, or unconsciousness
    - Unexplained convulsions

    (California Childcare Health Project, 1991)
- Assess poison hazards in the child care setting and instruct the staff in ways to reduce/eliminate the risks.

Reducing the Risk of Poisoning in the Child Care Facility

The *CFOC* standards recommend that child care health providers take the following actions to reduce the risk of poisoning in the child care facility.

  - Lock all toxic substances in a cabinet that is inaccessible to children.[5.100]
  - Make sure all toxic substances are clearly labeled. [5.100]
  - When toxic substances must be stored in the same room as food items, store them in a separate and clearly labeled cabinet away from food items. [4.060]
  - If the manufacturer's "Material Data Safety Sheet" for any product used in the child care facility shows the presence of toxic effects, replace the product with a non-toxic substitute. Otherwise, eliminate the product altogether.[5.102]
  - Use only chemicals approved by the EPA as "non-restricted." Store chemicals as any other toxic material – in their original containers, clearly labeled, and under lock and key.[5.100]

CFOC standards regarding poisoning

- Cleaning materials and other toxic materials shall be stored in their original labeled containers and shall be used according to the manufacturer's instructions and in a manner that will not contaminate play surfaces. When not in use, such materials shall be kept in

  a place inaccessible to children and separate from stored medications and food. (S 5.100,

4.060)

- Employers shall provide staff with information about the presence of toxic substances in use in the facility, such as asbestos, formaldehyde. This shall include identification of the ingredients of sanitizing products. Nontoxic substitutes shall be used if available. (S 5.102)
- All arts and crafts materials used in the facility shall be nontoxic. (S 5.105)
- Poisonous or potentially harmful plants on the premises shall be inaccessible to children. (S 5.106)
- The use of incense, mothballs, chemical air fresheners that contain toxic chemicals or materials emitting toxic substances shall be prohibited. (S 5.107, 5.109)
- Any surface and the grounds that children use shall be tested for excessive lead. Painted play equipment and imported vinyl mini-blinds shall be evaluated. Flaking or deteriorating lead-based paint shall be removed. (S 5.110)

Where to find more information

- Hawaii Poison Center **1-800-222-1222.**
- American Association of Poison Control Centers www.aapcc.org
- Centers for Disease control and Prevention www.cdc.gov
- Educational Development Center, Inc www.edc.org
- U.S. Consumer Product Safety Commission www.cpsc.gov
- Keiki Injury Prevention Coalition (KIPC)/SAFE KIDS Hawaii www.kipchawaii.org
- National Safe Kids Campaign www.safekids.org

Reference

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002
- National Training Institute for Child Care Health Consultants Staff. Injury prevention in child care. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001
- U.S. Consumer Product Safety Commission. Handbook for Public Playground Safety. U.S. Consumer Product Safety Commission, Washington , DC. Pub.No.325

4. SUDDEN INFANT DEATH SYNDROME (SIDS)

Background

- The National Institute of Child Health and Human Development (NICHD) defines SIDS as “the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination

of the death scene and review of the clinical history" (Beckwith, 2003, p. 288).

- The major cause of death in infants from 1 month to 1 year of age in the United States., with most deaths occurring between ages 2 and 4 months (AAP, 2000).
- It has been well-documented that the risk of SIDS can be reduced through supine sleep position, safe cribs, avoidance of soft bedding, eliminating exposure to secondhand smoke (Moon, Biliter, and Croskell, 2001), and through modifying other risk factors such as overheating and bed-sharing (AAP, 2000).
- Since 1992, when the American Academy of Pediatrics (AAP) recommended placing infants in the supine (back) position for sleep, the rate of SIDS decreased over 40% (AAP, 2000). The frequency of prone (tummy) sleeping has decreased from 70% in 1992 to 17% in 1998 (Moon and Oden, 2003).
- However, the proportion of SIDS deaths that occur in child care has remained constant, approximately 20% (Moon and Oden, 2003).

Role of the health consultant in reducing the risk of SIDS in child care

- Advise on safe sleep environment
- Recommend bedding and sleep structures that comply with the *CFOC* standards
- Provide educational materials to providers and parents on SIDS and risk reduction methods
- Encourage communication between parents and providers on the safe sleep position of infants
- Advise the providers on developing an action plan in the case of a SIDS death in the center
- Advise the provider regarding emergency procedures for an unresponsive child

CFOC standards regarding SIDS

- Scheduled rest periods and sleep arrangements. Unless the child has a note from a physician specifying otherwise, infants shall be placed in a supine position for sleeping to lower the risks of SIDS. (S 3.008)
- Death (SIDS or other) in child care (S 3.089)
- Infant sleeping position equipment and supplies (S 5.146)

Where to Find More Information

American Academy of Pediatrics. AAP revises recommendations on reducing the risk of SIDS. [online] 2005. Available from URL: http://www.aap.org/ncepr/sids.htm

American Academy of Pediatrics, Healthy Child Care America. Healthy child care America back to sleep campaign. [online] 2003. Available from: URL: http://www.healthychildcare.org/section_SIDS.cfm

Safe Sleep Hawaii
Department of Health, Maternal and Child Health Branch
Tel: 808/733-4056

American SIDS Institute
509 Augusta Drive
Marietta, GA 30067
Tel: 800/232-SIDS
Available from: URL: http://www.sids.org

First Candle/SIDS Alliance
1314 Bedford Avenue, Suite 210
Baltimore, MD 21208
Tel: 800-221-7437; 410/653-8226
Email: info@firstcandle.org
Available from: URL: http://www.sids-id-psc.org/

Moon RY, Patel KM, Shaefer SJ. Sudden infant death syndrome in child care settings. *Pediatrics*. 2000;106(2):295-300.

National Institutes of Health
National Institute of Child Health and Human Development
Back to Sleep Campaign
Bldg 31, Room 2A32, MSC 2425
31 Center Drive
Bethesda, MD 20892-2425
Tel: 800/ 505-CRIB (2742)
Available from: URL: www.nichd.nih.gov/sids/sids.cfm

National Resource Center for Health and Safety in Child Care
UCHSC at Fitzsimons
Campus Mail Stop F541; P.O. Box 6508
Aurora, CO 80045-0508
Tel: 800/598-KIDS (5437)
Email: natl.child.res.ctr@uchsc.edu
Available from: URL: http://nrc.uchsc.edu/
At homepage, type: SIDS *into Search window*

National SIDS/Infant Death Resource Center (NSIDSRC)
8280 Greensboro Drive, Suite 300
McLean, VA 22102
Tel: 703/821-8955; 866/866-7437
Email: sids@circlesolutions.com
Available from: URL: http://www.sidscenter.org

U.S. Consumer Product Safety Commission (CPSC)
Washington, DC 20207-0001
Tel: 800/638-2772
TTY: 800/638-8270
Email: info@cpsc.gov
Available from: URL: http://www.cpsc.gov

CHAPTER IV – Promoting Health and Safety

C. Social-emotional-behavioral health in Child Care

Children's mental health

A child's mental health is his/her state of emotional development (feeling and expectations of self) and social development (feelings about and expectations of others). Infant mental health is "the development capacity of the children from birth to 3 to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn-all in the context of family, community, and cultural expectations for young children." (ZERO TO THREE, 2002, p.2)

Definitions of mentally healthy feelings and behaviors vary with children's individual development and family/cultural characteristics. For example, biting another child might be a normal behavior for an 18-month-old but a sign of emotional distress for a 4-year-old; avoiding eye contact with an adult may be appropriate in a child from one culture but a sign of abuse from another culture.

Characteristics of mentally healthy young children (Greenspan & Greenspan, 1985):

A child's emotional and social developments occur in the context of the relationship with a primary caregiver in the first few years of life. It lays the foundation for lifelong mental health. Greenspan and Greenspan (1985) list some general characteristics:

- ☺ Positive self-esteem.
- ☺ A capacity for warm and trusting relationships with other children and adults.
- ☺ Developmentally-appropriate expression of their feelings and needs.
- ☺ Developmentally-appropriate control of impulses and behavior.
- ☺ Initial signs of the development of empathy and compassion for others.
- ☺ Initial development of skills to focus attention and make plans as a basis for learning.

Characteristics of mentally healthy family (Doub and Scott, 1987):

Doub and Scott (1987) identify the characteristics of mentally healthy families as:

- ☺ Adults are the leaders and role models. They are respected and they make and enforce the plans and rules.
- ☺ Children feel they belong and are valued. They are encouraged to participate in and contribute to family activities.
- ☺ Communication is clear and fair. Family members are encouraged to participate in and contribute to family activities.
- ☺ Changes are expected, and the family is able to respond to those changes.
- ☺ Outside help is sought and utilized when needed.

Mental Health Development

A child's social (feeling and expectation of others) and emotional (feeling and expectation of self) development occurs in the context of relationships with those caring for them. First, through a warm responsive relationship with an adult, the child's feelings of security, trust, confidence and well being grow. Second, social and emotional wellness has an impact on the child's brain development. Third, established healthy relationships that older children have with

their caregivers have an impact on their cognitive development, thus acting as a factor for determining school readiness (ZERO TO THREE, 2002).

Role of health consultant

- Learn as much as possible about mental health issues as they relate to children and early childhood care and education. Transmit relevant information to child care providers and family members.
- Network with community groups to reinforce a positive attitude towards child mental health needs and resources.
- Assist child care providers to be familiar with and appropriately use community resources including professional mental health services and to develop a mental health resource file.
- Encourage and assist the child care programs in developing mental health policies and procedures appropriate for staff, children and families.
- Make certain that child care providers are well aware of the methods for promoting mental health in child care.
- Work with child care providers to develop a consistent method for observing and documenting information about socio-emotional behavioral concerns and difficulties, and for sharing this information with family members.
- Assist the child care providers to develop policies about when and how to seek professional mental health consultation.

How child care programs can promote children's mental health (with Ref. to CFOC standards)

- A child's warm and responsive relationship with his/her primary caregiver in the first few years of life lays the foundation for life long mental health. Child care program can promote such relationship by: maintaining adequate adult:child ratio, small group sizes, assigning children a primary caregiver, and maintaining the continuity with that caregiver over the time the child attends the program. (S 2.010, 2.021)
- Child caregivers must get to know each child (his/her development, temperament, likes and dislikes and past experiences) and work to meet the child's particular needs. Caregivers should use parents as a bridge to understand and build a relationship with the child. (S 2.004, 2.054)
- All children experience stressful life events at some time that challenge their mental health. Child caregivers can support children's resiliency by assuring that:
  - Each child has a caring relationship with at least one adult
  - Each child has an opportunity for meaningful participation and responsibility
  - The caregiver has high expectations for each child and believes that each child can make a contribution
  - The caregiver recognizes each child's abilities

How child care program can assist children with social and emotional difficulties

a) Identify children with social and emotional difficulties
   - Important risk factors

     Be alert to those children with particular risk factors and observe more closely for signs of distress and provide them with extra support. Important risk factors include: family stress, neglect or abuse, or special medical/developmental needs.

- Behavioral “red flag”
  While provider’s main focus should be observing and supporting children’s prosocial, successful behaviors, s/he should be attentive to behavioral red flags that indicate social and emotional difficulties. The “red flag” behavior is often characterized as: emotional extreme, inappropriate for the child’s age/development stage, hurtful to him/herself or others, difficult in that others have trouble forming a positive relationship with him/her, driven, excessive, persistent, and/or out-of-control.

- Confirming behavioral concerns
  While all children experience difficult emotional and social episodes, these may become mental health problems when the difficulties persist over a period of time and in different settings. Providers should observe and document the child’s behavior over a period of time and in a range of different relationships, and confirm concerns about problem behaviors with parents, supervisors and/or mental health professionals.

b) Respond to children’s mental health problem
Caregivers must use their understanding of the individual child to interpret the meaning of the child’s behavior and to respond to the child’s needs. A child’s behavior is often prompted by a combination of causes. The art of responding appropriately is in taking many factors into consideration. In trying to interpret the causes of a troubling behavior, caregivers should consider the followings and respond accordingly:

- Child’s developmental skills; each developmental stage has predictable behavior that accompanies it. Some of these behaviors can be frustrating for caregivers but they are a normal part of child development.
  How to respond:
  - Remember that this is normal for children to do,
  - Channel the behavior, allow it in certain places at certain time,
  - Explain why not to do the behavior and teach how to do it correctly,
  - Give encouragement for small successes and be patient with failures
  - Stop the behavior when it is disruptive or dangerous

- Individual traits; each child is born with unique physical characteristics and temperament. These characteristics influence how the child experiences and responds to his/her environment.
  How to respond:
  - Accept the child’s unique qualities
  - Adapt expectations and interactions to fit the child’s abilities and style
  - Offer acceptable options for activities that are consistent with the child’s way of expressing him/herself

- Home environment; including the language, culture, food preferences, and rules for behavior, influence the child’s behavior and response to child care.
  How to respond:
  - Get more information from the parents and professionals

- When possible, change or adapt expectations in child care to accommodate the child's family and culture
- Provide support and help for the child, focus on things that can be controlled
- If there is reasonable suspicion of child neglect or abuse at home, caregivers are legally obligated to report to Child Protective Services

– Child care environment; the child's entire experience in the child care program shape the child's behavior. When children act out in response to features of the child care environment, their behavior will improve when the caregiver changes his/her own behavior, activities or the environment.

c) Child care program can benefit from the support of early childhood mental health professionals. It is appropriate for child care programs to seek mental health consultation. Consultation can offer support with severe mental health problems as well as common developmental experiences that are stressful for children, parents and providers. Child care programs can work with early childhood mental health professionals in a variety of ways depending on the program's mental health needs, program priorities, its resources (funding) and availability of community resources.

Reference

- Doub G, Scott VM. Survival skills for healthy families: family wellness workbook. Santa Cruz (CA): Family Wellness Associates;1987
- Greenspan S, Greenspan NT. First feelings: milestones in the emotional development of your baby and child from birth to age four. New York: Viking Penguin Inc.; 1985
- Bredekamp, S., & C. Copple, eds. 1997. Developmentally appropriate practice in early childhood programs. Rev.ed Washington, D.C.:NAEYC.
- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002
- National Training Institute for Child Care Health Consultants Staff. Promoting mental health in the child care setting. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001

Where to Find More Information

- Council for Exceptional Children – Division for Early Childhood (CEC-DEC) www.cec.sped.org
- Federation of Families for Children's Mental Health http://www.ffcmh.org
  9605 Medical Center Drive, Suite 280, Rockville, MD 20850
  Office: 240/ 403-1901 Fax: 240/ 403-1909
  ffcmh@ffcmh.org
- Research & Training Center on Family Support and Children's Mental health www.rtc.pdx.edu
- Parenting Tool Box www.parentingtoolbox.com

- American Academy of Child & Adolescent Psychiatry www.aacap.org
  3615 Wisconsin Ave., N.W., Washington, D.C. 20016-3007
  voice: 202-966-7300 fax: 202-966-2891

- National Mental Health Association Information Center www.nmha.org
  2001 N. Beauregard Street, 12th Floor
  Alexandria, VA 22311
  Phone 703/684-7722
  Fax 703/684-5968
  Mental Health Resource Center 800/969-NMHA
- NAMI Hawaii (National Alliance for Mentally Ill) 591-1297
  email Mpoirl14016@aol.com
- SAMHSA's National Mental Health Information Center www.mentalhealth.org

CHAPTER IV – Promoting Health and Safety

D. Infectious Disease

Background

- Parents of children attending child care facilities report missing from 1 to 4 weeks of work per year caring for ill children. (Davis, Mackenzie and Addis, 1994)
- Children in child care who are under 3 years of age are 3.5 times more likely, and children age 3 to 5 are twice as likely, to have an acute gastrointestinal illness than home reared children. (Kotch and Bryant, 1990)
- Infections acquired in child care settings that are mild or asymptomatic in children may be severe in adults. (Pickering and Osterhoim, 1997)
- Consequences of the higher occurrence of infectious disease in out-of-home child care include increased medical costs, decreased productivity, lost wages, and extra child care costs in addition to the discomfort associated with illness itself.

Modes of Transmission of Infectious Diseases in the Child Care Setting

- **Respiratory**; most commonly transmitted through direct contact. Examples are recurrent otitis media, meningitis, pharyngitis, upper and lower respiratory infections.
- **Fecal-oral**; the most important risk factors are the presence of diaper-aged children in the center and the mouthing behaviors. Other risk factors are large numbers of children in a group, inadequate hygiene practices by staff, and environmental fecal contamination. Examples are hepatitis A and Gastroenteritis.
- **Skin to skin**; transmitted through direct skin contact or contact with contaminated clothing. Examples are varicella, impetigo, scabies etc.
- **Blood, urine and saliva**; risk factors are unhygienic age-specific behaviors such as mouthing and the presence of diapered children. Examples are cytomegalovirus, hepatitis B, herpes simplex virus and HIV

Prevention of Infectious Disease

- **Prevention through immunization.** Hawaii requires age-appropriate immunization of children attending child care programs. (See appendix for immunization schedule) Written documentation of a child's immunization should be retained and updated at the child care center. The staff should also be current for adult immunizations.

- **Prevention through disease management**
  - Staff training and persistent monitoring of hygienic practices.
  - Environmental sanitation policies.
  - Systemic screening of staff for communicable diseases, e.g. tuberculosis.
  - Continuous monitoring of the health of all children and staff to insure early detection of disease and prompt implementation of control measures.
  - Policies for addressing control of infectious diseases.
  - Policies for reporting outbreaks of communicable infections.

Roles of Child Care Health Consultants

- Increase child care providers' awareness of infectious diseases and communicate this information in a way that they can understand and share with the parents.
- Be knowledgeable about the state regulations and licensing requirements that apply to infectious disease transmission. For example, staff child ratio, square footage requirements for outdoor and indoor space, sanitation requirements, immunization requirements and disease management policies. (refer to DHS child care center regulations and HCCH licensing checklist)
- In the area of disease prevention, assist with policy development and implementation, education and referral to agencies and resources.
- Assist staff in writing policies that will minimize the spread of disease, and developing methods to insure that the policies are appropriately and consistently carried out. Disease prevention is reflected in policies addressing the physical environment (number of children, location of sinks, supplies, ventilation and use of space etc.), protocol for hygiene (hand washing, diaper changing, sanitizing of toys, handling of body fluid), protocol for exclusion of sick children and immunization of children and staff.

CFOC Standards

Chapter 6 of the CFOC performance standards lists different types of childhood diseases; the recommended immunizations, what is required to be reported to the public health authorities, how to inform parents of exposures, attendance or exclusion of children, and staff education or detection of diseases.

Disease	***Page Number***	***Standards***
Haemophilus Influenzae Type B	285-286	6.001-6.003
Streptococcus Pneumoniae	286-287	6.004-6.005
Meningococcal Infections	287-288	6.006-6.008
Pertussis	288-289	6.009-6.011
Group A Streptococcal Infection	290	6.012-6.013
Tuberculosis	291-292	6.014-6.015
Erythema Infectiosum (EI)	292	6.016
Unspecified Respiratory Tract Infection	292-293	6.017
Herpes Simplex Virus	293-294	6.018
Varicella-Zoster Virus	294-295	6.019-6.020
Cytomegalovirus (CMV)	295-296	6.021-6.022
Enteric (Diarrheal) and Hepatitis A Virus Infections	297-300	6.023-6.026
Hepatitis B Virus (HBV)	301-303	6.027-6.031
Hepatitis C Virus (HCV)	303	6.032
Human Immunodeficiency Virus (HIV)	303-305	6.033-6.036
Scabies	305-306	6.037
Pediculosis Capitis (Head Lice)	306	6.038
Ringworm	306	6.039

Reference

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002
- National Training Institute for Child Care Health Consultants Staff. Infectious disease in child care settings. Chapel Hill (NC): National Training Institute for Child Caring for Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001

- Davis JP, MacKenzie WR, Addis DG. Recognition, investigation, and control of communicable-disease outbreaks in child day-care settings. Pediatrics 1994;94(suppl):1004.

- Kotch JB, Bryant D. Effects of day care on health and development of children. Current Opinion in Pediatrics 1990;2:883-894.

- Pickering LK, Osterholm MT. Infectious diseases in children and adults associated with out-of-home child care. In Long SS, Prober CG, Pickering LK (eds): Principles and practices of pediatric infectious diseases. New York: Churchill Livingstone; 1997, in press.

Where to find more information

- National Institute of Allergy and Infectious Diseases www.niaid.nih.gov
- NCID National Center for Infectious Diseases www.cdc.gov/ncidod/index.htm
- The ABC's of Safe and Healthy Child Care www.cdc.gov/ncidod/hip/abc/abc.htm
- An Ounce of Prevention: Keeps the Germs Away www.cdc.gov/ncidod/op/
- School Immunization Requirements www.immunize.org/laws/index.htm
- Childhood Immunization Schedule www.immunize.org
- Hawaii Immunization Program
  www.hawaii.gov/health/family-child-health/immunization/splash2.html
  1250 Punchbowl Street,
  Honolulu, HI 96813
  (808)586-8300
  1-800-933-4832

CHAPTER IV – Promoting Health and Safety

F. Nutrition

Background

- Early food and eating experiences are the foundation for the formation of attitudes about food, eating behavior, and consequently lifelong healthy eating habits.
- Three important elements of child care nutrition are:
  - Food served must be safe
  - Food served must meet children's nutritional needs and be appealing to them
  - Nutrition program must promote good eating habits.
- Child care program shall have access to nutritional information provided by a qualified nutritionist or other community resource (Hawaii Administrative rule 17-892.1-26). The nutrition specialist supplies expertise, guidance and consultation, and in-service training to the staff.
- The CACFP (Child and Adult Care Food Program), administered by the U.S. Department of Agriculture (USDA), supports good nutrition and quality child care in eligible child care centers/homes by providing reimbursement for meals served that meet certain nutrition standards. Nutrition education is also provided for participating child care providers.
- A written child care program nutrition plan should address the following:
  - Food safety, including food procurement, preparation, and service
  - Maintenance/cleaning of areas and equipment used for storage, preparation, and service of food
  - Infant feeding practices
  - Menu planning to meet the nutritional needs of the children
  - Classroom activities and mealtimes that promote healthy food habits.

The Role of the Child Care Health Consultants

- Review or assist in developing the nutrition plan. CCHC should be aware of available nutrition specialist or other resources in the community for consultation purpose.
- Periodically review with the child care staff the steps for sanitizing/disinfecting the food environment and food related items in the child care center.
- Periodically review with the child care staff how, when and where to wash hands.
- Assist child care providers in developing individualized infant feeding practices with input from each child's physician and parents, including children with special health needs. (or ensure a nutrition specialist is providing such services)
- Assist child care providers in encouraging and supporting mothers who breastfeed their infants in child care.
- Provide appropriate guidance to the child care provider on the developmental sequence of feeding skills and CACFP requirements. (or ensure a nutrition specialist is providing such services to the provider)

CFOC Standards

- Child care program shall have a nutrition plan that addresses kitchen layout, food procurement, preparation and services, staffing and nutrition education. (S 8.035, 4.001,4.027,4.069)
- Standards for food safety.
  - Provider is responsible for selecting safe, clean and wholesome food. (S 4.052, 4.037)
  - Food should be stored properly both before and after cooking, including preparation and storage of food in the refrigerator as well as foods not requiring refrigeration. (S 4.047, 4.053-4.057)
  - Selection and preparation of food brought from home. (S 4.040, 4.041)
  - Meals from outside vendor or central kitchens. (S 4.066, 4.067)
- Food sanitation. Cleanliness is very important in the child care center. In order to reduce the spread of germs and to protect everyone from illness, food, hands, food preparation areas, equipment, utensils, dishes, and containers must be kept clean.
  - Handwashing is one of the best ways to prevent the spread of germs. (S 4.046)
  - Cleaning and sanitizing food preparation areas (sinks, countertops etc.), storage areas (including cleaning supplies and storage of garbage), and food service equipment (cutting board, dishwashing, microwave etc.) are as important as handwashing. (S 4.042 - 4.049, 4.058 - 4.065)
- Meeting nutritional needs of children.
  Nutrition for infants
  - Preparation and handling of bottle feeding (breast milk or formula). (S 4.013 - 4.020)
  - Feeding solid food to infant. (S 4.012, 4.021)

  Nutrition for toddlers and preschoolers
  - Meal pattern, portions, developmentally appropriate utensil, (S 4.022 - 4.024, S 4.028 - 4.029)

- Mealtime activities and nutrition education
  - Mealtime supervision for infants and preschool children. (S 4.030, 4.035 - 4.039)
  - Socialization during meals and older children participating in mealtime activities. (S 4.031, 4.032)
  - Nutrition learning experience for children and education for parents. (S 4.069, 4.070)

References

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002

- Graves DE, Suitor CW, Holt KA, editors. Making Food Health and Safe for Children: How to meet the National Health and Safety Performance Standards-Guidelines for Out-of-Home Child Care Programs. Arlington(VA): National Center for Education in maternal and Child Health; 1997

- National Training Institute for Child Care Health Consultants Staff. Nutrition in child care. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001

- Hawaii Administrative Rules, Title 17, Department of Human Services, Subtitle 6 .Chapter 892.1, Licensing of Group Child Care Centers and Group Child Care Homes

Where to Find More Information

- United States Department of Agriculture. Tips for Using the Food Guide Pyramid for Young Children 2 to 6 Years Old. www.usda.gov/cnpp/KidsPyra
- US Department of Health & Human Administration for Children & Families, Head Start Bureau. Head Start Nutrition Education Curriculum. www.bmcc.org/Headstart/NECurriculum/index.html
- Bright Futures in Practice: Nutrition Second Edition www.brightfutures.org/nutrition/pdf
- American Dietetic Association. www.eatright.org
- American Diabetes Association www.diabetes.org
- American Heart Association www.americanheart.org
- National Dairy Council www.dairyinfo.com
- La Leche League www.lalecheleague.org

F. Children Who Are Ill or Temporarily Disabled

Background

- Mild illness such as respiratory infections and gastrointestinal problems are part of childhood; and as such they significantly impact the field of child care.
- Children who recover from temporary illnesses (surgery, fractures, burns) may also need child care.
- The care of mildly ill children in group programs generates controversy. The child's needs, the parent's need to work, the staff's ability to give the necessary attention to the sick child must be considered.
- The American Academy of Pediatrics states that the child care center should have a written policy concerning the management of sick children. This policy should be conveyed to parents at the time a child is registered. (AAP, Health in Day Care)
- Appropriate reasons to exclude mildly ill children: (Healthy Young Children, A Manual for Programs)
  - The child's disease is highly communicable
  - The child does not feel well enough to participate
  - Staff is not able to adequately care for sick and well children at the same time.
- It has been common practice for child care centers to require parents to pick up their children if they become ill during the day. To keep the infant or child in the program even temporarily, the provider must consider:
  - A quiet space separate from the other children where the mildly ill child can rest
  - Adequate staffing to watch and care for the sick child without neglecting the care of other children
  - Staff receives training to recognize the child who requires prompt medical attention.
- Giebink (1993) emphasizes the psychological/emotional as well as physical aspects of children's illnesses: "Provision for emotional support, nutrition, and attention to the child's developmental needs are as important as specific medical therapies and provisions for physical needs in caring for the ill children."
- Dilemmas for providers, parents and health care providers for ill children
  - The parents are concerned about the child's medical and physical condition. They want to be available to nurture their child. On the other hand they are concerned about job related issues.
  - The child care providers are concerned about providing the best care to the individual child but at the same time preventing the spread of infectious diseases to other children. They worry about making correct decisions regarding exclusion of ill children. They also face a dilemma when they are willing to take care of mildly ill children but feel the child would recover more rapidly and be more comfortable at home.
  - When the health care providers make decisions about the child's treatment, they must consider what is best for the health of the child. However, the needs of the

parents, the child care providers and the health of other children must also be considered.

- Kendrick, Kaufmann and Messenger suggest a flexible policy in excluding mildly ill children. "Every case is different and should be decided individually by staff and parents together using guidelines and procedures developed in consultation with health professionals." The basic question is can the child participate with reasonable comfort and receive adequate care without interfering with the care of the other children.

Role of health consultants

- With respect to the exclusion issue, child care health consultants should:
  - Understand the varying needs and perspectives of those involved – parents, child care providers, employers and health care providers.
  - Facilitate communication among these various parties.
  - Assist the child care center in determining the purpose for their exclusion criteria and in the development of exclusion policies and procedures which are consistent with state regulations.
  - Work as an advocate on behalf of children who are ill or temporarily disabled.
- Reinforce a holistic view of the child's needs, in lieu of focusing only on the child's physical need.
- Help improve communication among parents, child care providers and health care providers
  - Help to develop a "symptom record" for parents and child care providers to share information about the child who is ill or temporarily disabled.
  - Develop resource library for parents and child care providers on topics such as handwashing, providing care for ill children, etc.
  - Help to develop a form letter to send to families about any exposures children may have to communicable diseases.
  - Assist the child care center to develop a form for medication consent and log.

CFOC Standards

- All facilities shall provide rest areas for children who need to rest off schedule, including children who become ill, at least until the child is picked up. (S 3.009)
- Health assessment in child care:
  - A daily health check shall be conducted when the child enters the center. (S 3.001, 3.002)
  - The child care center shall require a health record of each child entering the facility. The health record must comply with the requirements of school entry physical examination, tuberculosis clearance, and immunizations. (S 3.003 – 3.006)
- The child care center shall specify in its policies what severity levels of illness the center can manage and under which and what types of illness will be addressed. The policy will list the conditions the center shall temporarily exclude a child, or send the child home as soon as possible. It shall also list the conditions that do not require exclusion. Written exclusion policy shall be provided to parents. (S 3.064 – 3.069, S 3.087)

- The child care center shall have a written policy that complies with the state's reporting requirements for communicable diseases. (S 3.084 - 3.086, 3.088)
- The center shall have a written policy for the administration of prescription and/or nonprescription medication. The policy shall include written permission of the parent or legal guardian, labeling and storage of medications, administration log and training of caregiver to administer the medication. (S 8.021, 3.082, 3.083)
- The child care center shall have a written plan and training for handling medical emergency or threatening incidents like natural disaster or fire. (S 3.048 - 3.052, 8.022 – 8.027)
- All staff members providing direct care to children shall have training in pediatric first aid. At least one staff member who has completed training in first aid shall be in attendance at all times. At least one staff member shall be certified in CPR when children are involved in swimming or wading, or when a child with special health needs is enrolled. (S 1.026 – 1.028)
- Each child's health record shall include: parent completed child's health history, immunization, parents' consent for medical or emergency treatment, illness, medication or injury record. (S. 8.046 – 8.053, 3.005 – 3.006, 8.061 –8.064)

Reference

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- Kendrick AS, Kaufmann R, Messenger Kp. Healthy Young children, a Manual for Programs. 1995 Edition, Washington DC: NAEYC
- Giebink GS. Care of the ill child in day-care settings. Pediatrics. 1993

Where to find more information

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- American Academy of Pediatrics. Caring for Our Children (National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs), Video Series – Part 6: Illness in Child Care. 1995. Elk Grove Village, Illinois: AAP
- University of North Carolina School of Public Health. National Training Institute for Child Care Health Consultants Training Manual
- Healthy Child Care Pennsylvania, The Early Childhood Education Linkage System (ECELS) www.paaap.org
- National Association for Sick Child Daycare www.nascd.com

CHAPTER IV – Promoting Health and Safety

G. Children Who Are Abused or Neglected

Background

- The Child Abuse Prevention and Treatment Act (Public Law 93-427) was enacted in 1974. This Act established the National Center on Child Abuse and Neglect (NCCAN). All states were required to develop laws and reporting guidelines for child abuse.
- In 1988, the Child Abuse Prevention, Adoption and Family Services act amended PL 93-247. This amendment focused on children with special needs and their increased risk of abuse and/or neglect.
- In 1996, the Child Abuse Prevention and Treatment Act (CAPTA) was amended and reauthorized (PL104-235). NCCAN is replaced by OCAN, the Office on Child Abuse and Neglect under the Administration on Children, Youth and Families, DHHS.
- Child abuse and neglect is defined as physical injury, psychological abuse and neglect, sexual abuse, negligent treatment, or maltreatment of a child under eighteen years of age by a parent, legal guardian or person responsible for that child's care under circumstances which indicate that the minor's health or welfare has been or is harmed or threatened with harm. (Hawaii state Department of Human Services Administrative Rule 17-920.1)
- According to the State of Hawaii Department of Human Service fiscal year 2001 report, 2,971 children in Hawaii were found to be victims of child maltreatment. In the majority of cases (67%), children with confirmed reports were threatened with harm to their safety. Other types of maltreatment include neglect/deprivation (13%), physical abuse (10%), sexual abuse (6%), psychological abuse/neglect (3%) and medical neglect (1%).
- In 1999, there were an estimated 826,000 victims of maltreatment nationwide. Almost three-fifths of all victims (58.4%) suffered from neglect and the most victimized children were in the 0-3 age group. (National Clearinghouse on Child Abuse and Neglect Information)
- An estimated 1,100 children died as a result of abuse and neglect in 1999. Children under age 6 accounted for more than three-quarters and infants under 1 year of age comprised approximately 43% of these deaths.

Role of the child care health consultants

- Advocate for the protection of all children, especially those enrolled in out-of-home child care.
- Keep informed about trends in child abuse and neglect, research in prevention strategies, changes in legislation. Educate providers and parents on this topic.
- Maintain a list of community resources for consultation and referral.
- Make certain that child care providers understand the state definitions of child abuse and neglect. Insure that child care providers are aware of the common behaviors, symptoms and signs displayed by children who have been abused or neglected.
- Insure that child care providers know the chronic and situational factors that lead to abuse.
- Assist in developing the written policies of child care programs regarding the monitoring, confirming and reporting of child maltreatment.

- Make certain that child care centers provide required instructions about child abuse and neglect reporting to all staff and volunteers.

CFOC standards

- Child care workers are mandated to report suspected child abuse and neglect. Care givers and health professionals shall establish linkages with child psychiatrists, physicians or other professionals who are knowledgeable about child abuse and neglect and are willing to provide them with consultation about suspicious injuries or other circumstances that may indicate abuse or neglect. (S 3.053 - 3.055)
- Caregivers shall know methods for reducing the risks of child abuse and neglect. They shall know how to recognize common symptoms and signs of child abuse and neglect. They shall have access to specialized training and expert advice if abused children are enrolled. (S 3.056, 3.057)

Reference

- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002
- National Training Institute for Child Care Health Consultants Staff. Caring for children who are abused or neglected. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001
- State of Hawaii, Department of Human Services Report, Fiscal year 2001
- Hawaii Administrative Rules, Title 17, Department of Human Services, Subtitle 6 .Chapter 920.1, Child Protective Services

Where to find more information

- The National Child Abuse and Neglect Data System (NCANDS) Fact Sheet. http://nccanch.acf.hhs.gov/general/stats/index.cfm
- Frequently Asked Questions on Child Abuse and Neglect, National Clearinghouse on Child Abuse and Neglect Information http://nccanch.acf.hhs.gov/admin/faqs.cfm
- Caregivers of Young Children: Preventing and Responding to Child Maltreatment http://nccanch.acf.hhs.gov/pubs/usermanuals/caregive/acknow.cfm
- Understanding the effects of maltreatment on early brain development, National Clearinghouse on Child Abuse and Neglect Information http://nccanch.acf.hhs.gov/pubs/focus/earlybrain.cfm
- NCPCA, National Committee to Prevent Child Abuse www.childabuse.org
- Prevent Child Abuse America www.preventchildabuse.org
- Prevent Child Abuse Hawaii, Telephone: (808) 951-0200, Fax: (808) 941-7004 E-mail: pcah@aloha.com
- Center on Family, "You Can't Beat'Em" project http://uhfamily.Hawaii.edu/projects/kidscantbeatem/kidscantbeatem.asp
- Parents and Children Together, CPS (child abuse prevention) Visitation Center www.pacthawaii.org/cps.html

CHAPTER IV – Promoting Health and Safety

H. Inclusion of Children With Special Needs

Background

- Children with special needs are defined as those children with developmental disabilities, mental retardation, emotional disturbance, sensory or motor impairment, or significant chronic illness who require special health surveillance or specialized programs, interventions, technologies, or facilities.
- The purpose of the Individuals with Disabilities Education Act (IDEA) is to provide a "free appropriate public education" to all eligible children, ages birth through 21 years, in a natural and/or least restrictive environment. (2nd edition, National Health and Safety Performance Standards)
- Part B of IDEA supports the needs of eligible three- and four-year old children through the local school district (DOE). Part C provides for a collaborative system to serve the needs of eligible infants and toddlers through early intervention (Early Intervention Section of DOH).
- Inclusion is the opportunity for children with special needs to participate in programs and activities alongside children without special needs. As a value, inclusion is not a legal definition nor a federal or state regulation. It supports the right of all children, regardless of their diverse abilities, to participate actively in natural settings within their community.
- Benefit of Inclusion
  - For children with special needs: promotes higher levels of socialization and developmental gains in language, motor, cognition, and play skills.
  - For children without disability: encourages respect, acceptance, and responsiveness to individual differences.
  - For families of children with special needs: supports positive feelings about inclusive settings, a capacity to identify benefits for their children, and the realization that an inclusive program does not mean giving up services.
  - For families of children without special needs: positive experiences may increase their respect, acceptance, and responsiveness to individual differences.
  - For child care providers: enhances awareness of all aspects of children's development, their individual needs and the capacity to function as a member of a larger team that includes other service providers and family members.
  - For the community: promotes knowledge, understanding, and acceptance of individual differences, access to high quality resources and services.
- Challenges of Inclusion
  - The values, beliefs and philosophies of individuals may influence their attitudes about inclusion.
  - Many child care providers have little experience or knowledge about developmental disabilities. Fear of the unknown can become the greatest obstacle to include a child of special needs.
  - Policies at the state, local and program level may present challenges to inclusion.
  - Lack of resources.

Role of child care health consultants

- Assist providers to develop a directory of names and telephone numbers of local agencies providing services to young children with special needs and their families.
- Be familiar with the eligibility requirements of lead agencies providing services to young children with special needs and their families. (DOE and DOH)
- Assist child care centers in defining inclusion as it applies to their program.
- Be able to share benefits of inclusion with child care programs.
- Be knowledgeable of the challenges of inclusion, assist programs in addressing these issues as appropriate.
- Strive to enable families to function as primary decision makers, caregivers, teachers and advocates for their child.
- Collaborate with the providers to ensure that adaptations and additional supports will adequately address the individual needs of children with special needs.
- Share information regarding integrated therapy to child care providers as appropriate.

CFOC standards

(Note: Standards for children with special needs have been integrated throughout the national performance standards with those for all other children to promote an inclusionary approach. Standards highlighted in this chapter are primarily those that apply solely to the general special service needs)

- Child care centers shall include children with disabilities and other special needs and children without disabilities in all activities possible. (S 7.001)
- Planning for needed resources, support, and education for staff and administrators to increase understanding and knowledge shall facilitate the inclusion of children with special needs. (S 7.002)
- Children with special needs and their families shall have access to and be encouraged to receive a multidisciplinary assessment (S 7.003)
- The Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) shall be developed for children identified as eligible in collaboration with the family, representatives from disciplines and organizations involved with the child and family, the child's health care provider and the child care center staff. The child care center shall designate one staff to be responsible for coordinating care within the center and with other service coordinators. (S 7.006, 7.007)
- If a child with special needs has an IFSP or IEP, the lead agency or the local education agency shall arrange and contract for specialized services to be conducted in the child care center. (S 7.009)
- The care coordinator shall ensure that formal reevaluations of the child's functioning and health care needs are conducted at least yearly, or as often as is necessary. (S 7.012)
- The caregiver shall seek technical assistance in developing and formulating the plan for future services for children with special needs. This plan shall be reviewed at least annually to see if it is in compliance with the legal requirements of the ADA and Section 504 of the Rehabilitation Act of 1973. (S 7.015, 7.016)

Referral for special need assessment or evaluation

H-KISS, Early Intervention Section (for children birth to three years old))
1600 Kapiolani Blvd. Suite 1401 955-7273
Neighbor Islands 1-800-235-5477

A free information and referral service for children under the age of 3. The family will be connected to a care coordinator who can help the child to be evaluated and to receive needed services.

Preschool Developmental Screening Program (for children 3-5 years old)
1700 Lanakila Avenue, Room 210 832-5675
Neighbor Island call collect

Free developmental screening for children aged 3 to 6. Inform the preschool or call the office directly if there are concerns about the child's growth. If follow-up testing is needed, program will assist family in obtaining most appropriate service.

Department of Education

For Information 733-4400 http://doe.k12.hi.us/specialeducation

If a child ages 3 through age 21 years of age is suspected to have a disability and may require special education, the parent may request an evaluation at the child's home school.

Reference

- Dennis BC, Laveck MS. Caring for children with special needs. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001
- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002

Where to find more information

- Wolery, R.A., & Odom,S.L. (2000). An administrator's guide to preschool inclusion. Chapel Hill: University of North Carolina, FPG Child Development Center, Early Childhood Research Institute on Inclusion
- NICHCY The National Information Center for Children and Youth with Disability www.nichcy.org
- KinderStart (indexed directory and search engine focused on children zero to seven on the 'net) www.Kinderstart.com
- U.S. Department of Justice, Civil Rights Division, Disability rights Section. Child care centers and the American with disabilities Act. www.usdoj.gov/crt/ada/chcaflyr.htm
- University of Kansas, Circle of Inclusion Project http://circleofinclusion.org
- University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center. National Early Childhood Technical Assistance System www.nectas.unc.edu
- Council for Exceptional Children – Division for Early Childhood www.dec-sped.org
- NAEYC position statement on Developmentally Appropriate Practice and Inclusion www.naeyc.org/resources/

CHAPTER IV – Promoting Health and Safety

I. Quality in Child Care

Background

- There are three basic components of quality in child care: (Harms T. Basic Components of Quality of Life for Early Childhood Education Programs)
  - Protection of children's health and safety and prevention of abuse and neglect
  - Building relationships with children, parents, extended family, and community
  - Opportunities for stimulation and learning from experience.
- Early childhood field is promoting voluntary accreditation for child care programs and credentialing for child care staff as approaches to improve quality (NTI). In Hawaii, credentials are obtained through:
  - Child care center accreditation offered by the National Association for the Education of Young Children (NAEYC)
  - Family child care home accreditation offered by the National Association for Family Child Care (NAFCC)
  - Child Development Associate (CDA) credential for staff offered by the Council for Early Childhood Professional Recognition
  - As of June 2002, there are 71 NAEYC accredited preschools or child care centers in Hawaii. A list of the accredited programs can be found at naeyc.org/accreditation/center.
- There are two major approaches to measuring the quality of early childhood programs. One approach uses structural indicators; staff-child ratio, group size, square footage per child etc. The other approach uses observation of ongoing process; such as staff-child, child-child interaction. The later approach found to be more predictive of child outcomes.
- The Harms, Clifford and Cryer Early Childhood Environmental Rating Scales are observation tools designed to assess process quality in an early childhood setting. They provide easy-to-use resource for defining high-quality care and assessing the level of quality offered in group programs.
  There are four sets of environmental rating scales designed to evaluate different types of programs. Each scale uses 35-49 indicators to measure the effectiveness of the program in the following areas; physical environment, basic care, curriculum, interaction, schedule and program structure and parent and staff education. The four scales are:
  - (ITERS) The Infant/Toddler Environmental Rating Scale; designed to assess group programs for children from birth to 2½ years of age. This scale consists of 35 indicators
  - (ECERS-Revised) The Early Childhood Environmental Rating Scale-Revised; designed to assess group programs for preschool through kindergarten-aged children (2 through 5 years old). This scale consists of 43 items
  - (FDCRS) The Family Day Care Rating Scale; designed to assess family child care programs conducted in a providers' home. This scale consists of 40 items

- (SACERS) The School-Age Care Environment Rating Scale; designed to assess before and after school group care programs for school-age children 5-12 years old.

- The rating scales are used in a variety of ways. They can be used as a tool for self-assessment by center staff, as preparation for accreditation and/or the environmental voluntary improvement efforts by licensing or other agencies.
- Observation is an essential tool for consultation. It is the key to understanding the current child care situation so that practical recommendations can be made for improvements in child care quality. (NTI)

Role of the Child Care Health Consultants

- Develop good observational skills through practice in child care to assist in identifying areas of strengths and weaknesses in child care programs.
- Child care health consultation includes not only physical health, but also mental health and social and intellectual development. Using the appropriate Environmental Rating Scale, the child car health consultants can become well acquainted with the day-to-day functioning of the child care program. Such knowledge enables the child care health consultants to provide practical, relevant support and encouragement to the child care staff for the improvement of quality.
- Having a comprehensive overview of all the basic components of quality helps the child care health consultants to make effective referrals through collaboration with individuals and agencies in related early childhood fields.
- Plan collaboratively with child care staff to improve the quality of their programs, follow up to see if plans of improvement are implemented.

Reference

- Harmes T, NTICCHC staff. Quality in early child care programs and how to measure it: the Infant/Toddler Environmental Rating Scale. Chapel Hill (NC): National Training Institute for Child Care Health Consultants, Department of Maternal and Child Health, The University of North Carolina at Chapel Hill, 2001
- American Public Health Association, American Academy of Pediatrics and National Resource Center for Health and Safety in Child Care. Caring for Our Children, National Health and Safety Performance Standards-guidelines for Out-of Home Child Care Programs, Second Edition. 2002

Where to find more information

- Early Childhood Environment Rating Scales www.fpg.unc.edu
- National Association for the Education of Young Children (NAEYC) for information on child care center accreditation guidelines www.naeyc.org/accreditation/
- National Association for Family Child Care www.nafcc.org
- 13 Indicators of Quality child Care: Research Update http://nrc.uchsc.edu
- Accreditation Criteria & Procedures of the National Association for the Education of Young Children. 1998 Edition, Washington DC: NAEYC
- Kendrick AS, Kaufmann R, Messenger Kp. Healthy Young children, a Manual for Programs. 1995 Edition, Washington DC: NAEYC
- Feeney S. & Freeman N., 1999. Ethics and the early childhood educator: Using the NAEYC Code. 1999. Washington , D.C.:NAEYC